STATEWIDE PLANNING TITLE VI COMPLAINT FORM

Contact Information		
Name		
Address:		
City:	**State:**	**Zip:**
Home Phone:	**Work Phone:**	
Email:		
Discrimination Complaint		
Name of Staff Person that You Believe Discriminated Against You:		
Date of Alleged Incident:		
You were discriminated because of:	**□ Race** **□ Sex**	**□ Color** **□ National Origin or (Language)** **□ Age** **□ Disability**
Explain as briefly and clearly as possible what happened and how you were discriminated against. Indicate who was involved. Be sure to include how other persons were treated differently than you. Also attach any written material pertaining to your case such as any persons (witnesses, fellow employees, supervisors, or others), if known, whom we may contact for additional information to support or clarify your complaint. (Please be sure to provide contact information, and use additional sheets if necessary.)		
Signature:		**Date:**